診　察　申　込　書　　　　　ＦＡＸ送信票

滋賀県立総合病院　宛　　　　　　　　　　　　　　　　　　　令和　 　年　 　月　　 日

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| 紹介医療機関名　　　　　　　　　　　　診療科名　　　　　　　医師名  ＴＥＬ　　　　―　　　　　―　　　　　　　　ＦＡＸ　　　　―　　　　　― | |
| 診察申込 | 診療科　　　　　　　　　　　 医師名（希望医師に○をお付けください）  　リハビリテーション科　　中馬医師　新里医師　丸木医師　川上医師　（　　　　医師）  受診希望日時  　　第１希望　　　月　　　日　　　時　　　分  　　第２希望　　　月　　　日　　　時　　　分 |

患　者　様　基　本　情　報

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| （ふりがなをお書き下さい）　　男　・　女  生年月日　　明　　大　　昭　　平　　令　　　　　年　　　　月　　　　日　　（　　　歳）  住所(〒　　-　　　)　　　　　　　　　　　　 　　　　　　ＴＥＬ　　　　-　　　　-  本院受診歴　　　無　・　有　→診察券番号（　　　　　　　　　　　　）できるだけ記入してください。  　感染症検査　　　未実施　・　実施済み　→　ＨＢｓＡｇ（　　　）、ＨＣＶＡｂ（　　　）  　　　　　　　　　　　　　　　　　　　　　　ＴＰＨＡ（　　　） 、ＭＲＳＡ（　　　）  患者様保険情報   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 保険者番号 |  |  |  |  | |  | |  | |  |  | | 記号　番号 |  | | | |  | | | | | | |  | | 資格取得年月日 | 年　　月　　日 | | | | | | | | | | |  | | 有効期限 | 年　　月　　日 | | | | | | | | | | | | 被保険者氏名 |  | | | | | | 続柄 | |  | | | | 一部負担金の割合 | 割 | | | | | | | | | | |  |  |  | | --- | --- | | **画像ﾃﾞｰﾀのＣＤ-Ｒ等** | | | **有**  **・**  **無** | **枚** |   国保・社会保険・後期高齢者  公費負担医療受給者証   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 負担者番号 |  |  | | |  | |  | |  | |  | |  | |  | | 受給者番号 |  | |  | | |  | |  | |  | |  | |  | | | 有効期間 | 年　　　月　　　日 | | | | | | | | | | | | | | | | 老人負担金割合 | | | | 割 | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 負担者番号 |  |  | |  | |  | |  | |  | |  | |  | | 受給者番号 |  | |  | |  | |  | |  | |  | |  | | | 有効期間 | 年　　　月　　日 | | | | | | | | | | | | | | |

**お申し込みは滋賀県立リハビリテーションセンター（下記番号）までファックスしてください。**

**ＴＥＬ０７７－５８２－９７１０　　　　ＦＡＸ０７７－５８２－５７２４**